PREMIER HEART CENTER
www.THEPREMIERHEARTCENTER.com
Trieu Ho, MD, FACC, FHRS
Clinical Cardiac Electrophysiologist

Medical Records Release Form

Authorization for use or Disclosure of Protected Health Information

Patient's Name: _____

Social Security Number: _____DOB: _____

Day time Phone Number: _____ Evening Phone Number: _____

Address:_____

City: _____ State: _____ Zip Code: _____

I herby authorize _____ to use or disclose my protected health information as indicated below to

Premier Heart Center: Phone: (682) 214-3486, Fax: (682) 214-3470

1. **Grapevine: 2020 W. State Hwy 114, Suite 130 Grapevine, Texas 76051**
2. **Alliance: 10840 Texas Health Trail, Suite 200 Fort Worth, Texas 76244**
3. **Decatur: 1713 S FM 51 Suite 103 Decatur, TX 76234**

Information to be released:

From & To Dates: _____

__ Copy of complete medical records

__ Nuclear stress test, holter, device check, OP reports

__History and Physical/ Consultation reports

__Laboratory, X-rays, EKG, Echocardiogram

__ Other _____

Purpose of Disclosure:

__Changing Physician __Second Opinion

__Continuing Care __Legal

__At my (patient) request __Insurance

__Worker's Compensation __School

Other:_____

I understand that this health information may include HIV-related information and/or information relating to diagnosis or treatment of psychiatric disabilities and/or substance abuse and that by signing this form, I am specifically authorizing the release of information relating to:

__ Substance Abuse (including alcohol/drug use)

__Mental Health

__Psychotherapy Notes

__HIV related information (including AIDS related testing)

Signature of Patient or Legal Guardian_____

Date_____

1. I understand that this authorization will expire two years from my last date of service. A photocopy of this form will be considered as valid as the original.
2. I understand that information used or discolored pursuant to this authorization may be subject to redisclosure by the recipient and no longer be protected by Federal privacy regulations. However, other state or federal law may prohibit the recipient from disclosing specialty protected information, such as substance abuse treatment information.
3. My healthcare and payment or my healthcare will not be affected if I do not sign this form.
4. I understand that I will get a copy of this form after I sign it. Signing below I acknowledge that I have read and understand this Authorization.

Signature_____ Relationship_____ Date_____